STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155307	A. BUILDING 00 B. WING	07/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWNE CENTRE HEALTH CARE	7250 ARTHUR BOULEVARD MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00093249. Complaint IN00093249 substantiated, Federal/State deficiencies related to the allegations are cited at F 225, F 226, and F 272. Survey dates: July 12, 13, and 18, 2011 Facility number: 000204 Provider number: 155307 AIM number: 100284910 Survey team: Janelyn Kulik, RN Census bed type: SNF/NF: 87 Total: 87 Census payor type: Medicare: 19 Medicaid: 55 Other: 13 Total: 87 Sample: 8 These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2.	F0000	Preparation and implementation of this plan of correction does not constitute admission or agreement by Towne Centre Health Care of the truth of the facts, findings, or other statements as alleged by the preparer of the survey/inspection dated 7-18-2011. Towne Centre Health Care specifically reserves the rights to move to strike or exclude this document as evidence in any civil, administrative, and criminal action not related directly to the licensing and/or certification of this facility or provider.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155307	A. BUILDING 00 B. WING	07/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWNE CENTRE HEALTH CARE	7250 ARTHUR BOULEVARD MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Quality review completed 7/21/11 Cathy Emswiller RN			
F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the	F0225	F 225	07/30/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155307	A. BUILDING 00 B. WING	07/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWNE CENTRE HEALTH CARE	7250 ARTHUR BOULEVARD MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	facility failed to ensure every suspected allegation of abuse was reported promptly to the Administrator, Indian State Department of Health, and was investigated for 1 of 2 residents reviewed with injuries of unknown origin in a sample of 8. (Resident #D) Findings include: The closed record for Resident #D was reviewed on 7/12/11 at 1:45 p.m. The resident's diagnoses included, but were not limited to, anemia, hypertension, cerebrovascular accident (stroke), diabetes, seizures, and depression. A nursing note dated 6/13/11 at 4:00 p.m., indicated the resident was at the nurse's station and the nurse observed a greenish-purple bruise on the resident's chin. The nurse asked the resident how it got there and the resident stated, "I don't know how it happened". The resident expressed no pain and was able to open and close his mouth without difficulty. The resident's lower gum line was intact with no bleeding noted. Interview with the Administrator on 7/18/11 at 9:30 a.m., indicated she could not remember if she had been told about the bruise and she would have to check into if the area was investigated and		1) Resident D was discharged from the facility. 2) All resident have the potential to be affected. Any bruise of unknown origin will be investigated and reported to the ISDH. 3) Residents with bruises of unknown origin will be immediately reported to the Administrator, Director of Nursing (DON) or Administrative designee. Health Care staff will be inserviced on reporting bruises by 7-30-11. 4) All residents receive weekly skin checks on shower days and bruises will be noted and reported to the Administrator, DON or Administrative designee. The Administrator, DON or Administrative designee will check to see if the bruise has been investigated and reported to the ISDH. If the bruise has not been reported, it will be reported at that time. All bruises will be reviewed monthly in the QA Committee meeting ongoing. 5) Completed by 7-30-11.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155307	A. BUILDING 00 B. WING	07/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWNE CENTRE HEALTH CARE	7250 ARTHUR BOULEVARD MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	reported. Interview with the Director or Nursing, Administrator, and LPN #1 on 7/18/11 at 10:00 a.m., indicated the area was investigated and the resident had indicated no one had hurt him. The injury of unknown origin was not reported to the Indiana State Department of Health, and they were not sure when the Administrator had been informed of the bruise. The Director of Nursing indicated during a meeting on 6/23/11 a CNA had indicated Resident #D would rest his chin on the toilet paper holder when he was in the bathroom. The Administrator then indicated yes but the bruise was observed on 6/13/11. LPN #1 indicated the resident had told her during an interview that no one hurt him and he would have told staff if someone had hurt him. Interview with the Director of Nursing on 7/18/11 at 12:43 p.m., indicated that when the bruise was found on Resident #D's chin the resident was interviewed but no staff or other residents were interviewed at that time. This Federal tag relates to Complaint IN00093249. 3.1-13(g)(1) 3.1-28(c)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155307	A. BUILDING 00 B. WING	07/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWNE CENTRE HEALTH CARE	7250 ARTHUR BOULEVARD MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-28(d)			
F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure the facility followed its abuse policy in regard to reporting all allegations of abuse to the Administrator, Indiana State Department of Health and investigation injuries of unknown origin for 1 of 2 residents reviewed for injuries of unknown origin in a sample of 8. (Resident #D) Findings include: The closed record for Resident #D was reviewed on 7/12/11 at 1:45 p.m. The resident's diagnoses included, but were not limited to, anemia, hypertension, cerebrovascular accident (stroke), diabetes, seizures, and depression. A nursing note dated 6/13/11 at 4:00 p.m., indicated the resident was at the nurse's station and the nurse observed a	F0226	F 2261) Resident D was discharged from the facility.2) All residents have the potential to be affected. Health Care staff will be inserviced on the Facility Abuse Prevention and Reporting Policy by 7-30-11.3) Any injury of unknown origin will be reported to the Administrator, DON or Administrative designee. The injury will be immediately investigated and reported to the ISDH. All resident will have weekly body assessments completed on shower days. Any findings will be reported to the Administrator, DON or Administrative designee. 4) The Towne Centre Executive Director (ED) will monitor by comparing facility incident reports and the Reports sent to the ISDH to assure compliance. The ED will report findings to the QA committee monthly ongoing.5) Completed by 7-30-11	07/30/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155307	A. BUILDING 00 B. WING	07/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWNE CENTRE HEALTH CARE	7250 ARTHUR BOULEVARD MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	greenish-purple bruise on the resident's chin. The nurse asked the resident how it got there and the resident stated, "I don't know how it happened". The resident expressed no pain and was able to open and close his mouth without difficulty. The resident's lower gum line was intact with no bleeding noted. The Abuse Prevention and Reporting Policy and Procedure was provided by the Administrator on 7/12/11 at 9:30 a.m. The purpose of the procedure was as follows: "To establish guidelines for policies and procedures that prohibit mistreatment, neglect and abuse of resident and misappropriation of resident property, and to assure the residents will be free of verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion by implementing procedures for screening, training, prevention, identification, investigation, protection and reporting/response to all allegations of abuse." The policy included the following: "It is the policy of Towne Centre Health Care to protect resident from mistreatment, neglect, and abuse of resident and misappropriate of resident property. The facility will not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. The facility will do all that is within its control to prevent			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155307	A. BUILDING 00 B. WING	07/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWNE CENTRE HEALTH CARE	7250 ARTHUR BOULEVARD MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	occurrences of abuse by screening and training employees, protecting residents, and preventing, identifying, investigating, and report/respond to allegations of abuse, neglect, mistreatment, and misappropriation of property." The definitions included, but were not limited to, Injury of Unknown source: "When both the source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and the injury is suspicious because the extent of the injury or the location of the injury (e.g. (that is), the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time." Immediately: "means as soon as possible, but ought not exceed 24 hours after discovery of the incident, in the absence of a shorter state timeframe requirement." The procedures included, but were not limited to, Identification: "The facility will identify any bruising of unknown origin or that may be suspicious in nature and investigate to attempt to determine cause. An incident report will be completed and reported to Unit Supervisor immediately. Any injury of unknown source must be investigated if both conditions are met: the source of the injury was not observed by any person or			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155307	A. BUILDING 00 B. WING	07/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWNE CENTRE HEALTH CARE	7250 ARTHUR BOULEVARD MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the source of the injury could not be explained by the resident; and the injury is suspicious in nature because of the extent of the injury or the location of the injury ect." Investigation: The facility will implement an Abuse investigation protocol. The protocol will include but was not limited to, "f) The supervisor will report incident to Administrator and/or Director Nursing. g) The Administrator and /or DON (Director of Nursing) will proceed with the investigation by obtaining initial statements of information relative to reporting Initial Report to the proper authorities." "j) A thorough investigation will be conducted including, but not limited to obtaining statements from other alert and oriented residents, staff, family members, witnesses to the event, at the time, at different times or shifts, on different floors, etc." Reporting/Response: "The Administrator or designee will contact the ISDH (Indiana State Department of Health) by telephone (telephone number) or fax (fax number) or by e-mail immediately within 24 hours upon determining a situation exists or existed that is reportable under the ISDH guidelines for reporting unusual occurrences.' Interview with the Administrator on 7/18/11 at 9:30 a.m., indicated she could			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155307	A. BUILDING 00 B. WING	07/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWNE CENTRE HEALTH CARE	7250 ARTHUR BOULEVARD MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	not remember if she had been told about the bruise and she would have to check into if the area was investigated and reported. Interview with the Director or Nursing, Administrator, and LPN #1 on 7/18/11 at 10:00 a.m., indicated the area was investigated and the resident had indicated no one had hurt him. The injury of unknown origin was not reported to the Indiana State Department of Health, and they were not sure when the Administrator had been informed of the bruise. The Director of Nursing indicated during a meeting on 6/23/11 a CNA had indicated Resident #D would rest his chin on the toilet paper holder when he was in the bathroom. The Administrator then indicated yes but the bruise was observed on 6/13/11. LPN #1 indicated the resident had told her during an interview that no one hurt him and he would have told staff if someone had hurt him. Interview with the Director of Nursing on 7/18/11 at 12:43 p.m., indicated that when the bruise was found on Resident #D's chin the resident was interviewed but no staff or other residents were interviewed at that time. This Federal tag relates to Complaint IN00093249.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155307	A. BUILDING 00 B. WING	07/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWNE CENTRE HEALTH CARE	7250 ARTHUR BOULEVARD MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-28(a)			
F0272 SS=D	The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155307	A. BUILDING 00 B. WING	07/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWNE CENTRE HEALTH CARE	7250 ARTHUR BOULEVARD MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on record review and interview ,the facility failed to assess a resident's transfer status for 1 of 6 residents reviewed for falls in a sample of 8 related to a resident returning from the hospital with a fractured humerus and her arm in a sling. (Resident #C) Findings include: The record for Resident #C was reviewed on 7/12/11. The resident's diagnoses included, but were not limited to, anxiety, depressive disorder, and congestive heart failure. A nursing note dated 4/17/11 at 5:30 p.m., indicated the resident was found on the floor in the dining room. There was no apparent injury noted at this time. The resident indicated she hit her head on the floor. There was no bleeding or open areas noted. The resident complained of left arm pain. An order was received to send the resident to the hospital. At 11:15 p.m. a call was received from the emergency room indicating the resident was admitted to the hospital with a fractured left humerus (upper arm bone). Review of a Resident Assessment-Data Collection Form dated 4/21/11, indicated the resident had a fractured left humerus. She had contractures of her left and right	F0272	F 272 1) Resident is using correct lift for transfer. 2) All residents have the potential to be affected. All new residents, re-admitted residents or residents with a change in status will be assessed for correct transfer status. 3) Nurses will be inserviced on Assessing Resident for Correct Transfer Status by 7-30-11. Upon completion, the results of the Transfer Assessment will be written on the Nursing Assistant Communication Sheet. 4) All new residents, readmitted residents or residents with change in status will be monitored by the DON, Unit Managers or Weekend Nurse Manager 7 days per week, to assure the correct transfer status has been identified and communicated to the direct care staff per the Nursing Assistant Communication Sheet. The DON will report to the QA Committee the results of monitoring Resident Assessments monthly and ongoing. 5) Completed by 7-30-11.	07/30/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155307	A. BUILDING 00 B. WING	07/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWNE CENTRE HEALTH CARE	7250 ARTHUR BOULEVARD MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	leg. She was a two person assist for transfers. A nursing note dated 4/21/11 at 9:00 p.m., indicated the resident had a bruise to her left upper arm with a fractured left upper arm. She complained of pain when moved. Her arm was in a sling at this time. A nursing note dated 4/22/11 at 10:00 a.m., indicated the resident's arm sling was intact. The resident denied discomfort unless being repositioned. A nursing note dated 4/26/11 at 10:00 a.m., indicated the resident's left upper extremity sling was intact. Her hand grasp was weak. The resident complained of pain when being repositioned or moved. A nursing note dated 4/27/11 at 2:45 p.m., indicated the resident was a 1-2 person assist due to her fractured left humerus, to which she wears a sling. She had complaints of pain and discomfort whenever the arm was moved. A nursing note dated 4/29/11 at 10:55 p.m., indicated the resident continued to wear a sling to her left arm due to a fractured humerus. Her arm was still very painful to movement and her range of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155307	A. BUILDING 00 B. WING	07/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWNE CENTRE HEALTH CARE	7250 ARTHUR BOULEVARD MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	motion was limited. A nursing note dated 4/30/11 at 1:25 a.m., indicated the resident continued to wear a sling to her left arm due to a fractured humerus. The resident complained of no pain or discomfort at this time. However, whenever her left arm was moved the resident complained of pain. A nursing note dated 5/2/11 at 11:36 a.m., indicated the resident continued with a sling to her left humerus fracture. The resident complained of left arm pain. The resident was a two person assist for activities of daily living and transfers, using a hoyer lift (a mechanical transfer device). A new order was received to discontinue a Sara lift (a mechanical lift, sit to stand lift) and start hoyer lift due to left humerus fracture. Review of a physician order dated 5/2/11 at 11:46 a.m., indicated fractured left humerus. Discontinue Sara lift for transfers. A new order for use of a hoyer lift for all transfers. A discharge Minimum Data Set Assessment dated 4/19/11, indicated the resident was an extensive assist with transfers, indicating the resident involved in activity, staff provided weight-bearing support with one person physical assist.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155307	A. BUILDING 00 B. WING	07/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWNE CENTRE HEALTH CARE	7250 ARTHUR BOULEVARD MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

A significant change Minimum Data Set Assessment dated 5/24/11, indicated the resident was totally dependent with transfers requiring full staff performance every time during the 7 day period with a two plus persons physical assist.

Review of a physical therapy plan of treatment dated 4/22/11, indicated the resident's prior level of functioning for transfers, sit to stand and stand to sit was minimal assistance routinely requiring 25% assist with transfer. Her current level of function was dependent requiring 100% assistance by one or more persons to transfer. She had pain with activity of 6 on a scale of 10. The pain was located in her bilateral shoulders.

A Demonstration for Sara Lift Form was provided by the Director of Nursing (DoN) on 7/12/11 at 2:50 p.m. She indicated there was no policy for the Sara lift but this was how the CNAs were inserviced on the lift. The procedure included, but was not limited to, "Ensure pt (patient) can reach and hold onto handles to aid in lifting process."

Interview with Physical Therapist #1 on 7/12/11 at 2:30 p.m., indicated the Sara Lift should not be used on a resident with a fractured humerus and arm in a sling.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155307	A. BUILDING 00 B. WING	07/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWNE CENTRE HEALTH CARE	7250 ARTHUR BOULEVARD MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	At 2:45 p.m. the Therapist indicated Resident #C should not have been a Sara Lift due to the contractures of her bilateral legs. He further indicated she should not have been a Sara Lift prior to her humerus fracture. Interview with the Second Floor Unit Manager on 7/13/11 at 7:30 a.m., indicated that when a Resident is admitted or readmitted to the facility the transfer method would be determined by therapy. The resident's are left in bed until therapy evaluates. Interview with Physical Therapist #1 on 7/13/11 at 7:35 a.m., indicated therapy does not always determine the initial method of transfer. If the resident would be admitted to the facility on a Saturday the resident would not be left in bed until the therapist evaluated the resident. At 7:40 a.m. the therapist indicated Resident #C was evaluated on 4/22/11 as dependent and should not have been a Sara Lift. Interview with the Director of Nursing on 7/13/11 at 3:05 p.m., indicated the CNA care sheets dated 4/18/11 and 4/24/11 for Resident #C indicated the method of transferring the resident was the Sara Lift. It was also indicated the method of transfer had been discussed in morning meetings. The CNAs had come to her and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155307	A. BUILDING 00 B. WING	07/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWNE CENTRE HEALTH CARE	7250 ARTHUR BOULEVARD MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	questioned it if was appropriate to the transfer Resident #C with the Sara Lift with her arm in a sling. She further indicated it was at this time the method of transfer was changed to a hoyer lift. She also indicated the staff had never mentioned the resident was having pain with transfers. This Federal tag relates to Complaint IN00093249. 3.1-31(c)(3)			